PEDIATRIC

RN GUIDELINES

ABUSE AND NEGLECT OF CHILDREN

Definition: Abuse: Injurious, harmful or offensive behavior destructive to the normal physical or emotional development of a child.

Neglect: Omission of necessary or appropriate attention that prevent a child's basic needs from being met.

Red Flag: Look for and note evidence of recent torture and abuse.

Suspicious findings or concerns should be referred immediately to the provider for evaluation of abuse and/or neglect

Notify the Clinical Director. ICE should be advised.

If evidence is positive for suspected abuse and/or neglect, contact Child Protective Services (CPS) and refer the patient to the nearest ER for further evaluation and work-up.

If you feel the patient may still be victimized by the abuser, advise ICE.

Carefully document all evidence of suspected torture and abuse, as it may be important to support/refute asylum claims.

Reinforce that once suspicion is reported as abuse, the provider is obligated to send the child out for evaluation by CPS.

Subjective:

Always be aware and on guard of the history that seems incongruent with the clinical presentation of the child.

1. Using nonjudgmental, declarative statements, ask patient if someone has hurt them either physically or with words.

1.1 "How were you hurt?"
1.2 "Has this happened before?"
1.3 "When did it first happen?"
1.4 "How badly have you been hurt in the past?"
1.5 "Was a weapon involved?" "What kind of weapon?"
1.6 "Who hurt you?"

Red Flags: Suicidal or homicidal thoughts, increased anxiety, panic attacks, flinching o n touch, flat affect, fear, vague complaints without physical findings, feelings of isolation and inability to cope, failure to thrive as evidenced by no weight gain or weight loss, inappropriate behavior for level of development.

Objective:

1. Vital signs
2. Chart review (Look for documented signes and symptoms of abuse such as broken bones, multiple visits for injuries
3. Emotional and Psychological Signs:
   3.1 Irritable,
   3.2 Nervous,
   3.3 Anxious,
   3.4 Pacing,
   3.5 Shouting,
   3.6 Crying,
   3.7 Cooperative,
   3.8 Demanding,
   3.9 Suspicious,
   3.10 Avoiding eye contact,
   3.11 Rigid,
   3.12 Clenched fists,
   3.13 Other body language and facial expressions.
4 Physical Exam/History: Any signs of injury – frequent sites of injury from abuse: head, chest, limbs, abdomen and genitalia. Look for evidence of recent torture, abuse or

neglect. Look for injuries in various stages of healing.

- 4.1 Skin: Burns, bruises, old healed scars, fingerprint marks, black eyes, scalding burns, etc.
- 4.2 Head: Decreased hearing from multiple blows, subdural hematomas, bulging or sunden fontanel, depressions of the skull
- 4.3 Eyes: Swelling, subconjunctival hemorrhage, bruising of the lids
- 4.4 Gastrointestinal: Non-ulcer dyspepsia, irritable bowel syndrome
- 4.5 Genital/Urinary: Bruises, tenderness, history of recurrent vaginal/pelvic complaints, symptoms of rape, or sexual assaultin either gender
- 4.6 Rectal: Bleeding, edema, irritation, lacerations
- 4.7 Musculoskeletal: Fractures, especially of the skull, radius, ulna, femur; shoulder or elbow dislocation; limited motion; old fractures; chronic pain. If fractures are suspected, obtain x-rays immediately.

5 It is important to use non-blaming language when speaking to possible victims and their parents. Statements that can be used include:

- 5.1 "I am concerned for your safety."
- 5.2 "I am here to help you."
- 5.3 "It is not your fault."
- 5.4 "I think I can help you if you will let me in."
- 5.5 "It is wrong (illegal) to beat/injure another person."
- 5.6 "You have the right to be treated with respect."

Red Flag: Does the patient have any physical signs of possible abuse (physical or sexual)? Note any in the progress notes.

6. REFER TO PROVIDER

Assessment:

1. Risk for/actual other-directed violence
2. Risk for trauma

3. Risk for post-trauma syndrome
4. Powerlessness
5. Chronic low self-esteem
6. Ineffective Coping
7. Sexual dysfunction
8. Delayed growth and development
9. Interrupted family processes/impaired parenting

Plan:

1. Provide privacy for patient.
2. Reassure patient that you and the medical staff are there to help them.
3. Remain calm, truthful and nonjudgmental.
4. Give permission to express angry feelings in acceptable ways. Make time to listen to verbalization of these feelings.
5. Separate from the parent if you have any reason to believe the child is in danger. Be sure another healthcare worker is present as a witness.
6. Refer patient to NP/PA/MD/DO and/or social worker/psychologist/psychiatrist ASAP.

Evaluation:

Follow-up visit as recommended by NP/PA/MD/DO.

Education:

Educate patient regarding the plan of care

ACNE IN PEDIATRIC PATIENTS

Definition: Inflammatory, papulopustular skin eruption,

Usually involving a bacterial breakdown of sebum.

Most often seen in adolescence to early adulthood.

Subjective: Factors influencing patient's condition:

1. Duration of current outbreak
2. Current medication(s)
3. Current and previous acne treatment
4. Allergy status
5. Facial hygiene - how often is patient washing face?
6. Dietary changes - has there been a recent change in diet?

Objective:

1. Obvious pimples, blackheads, whiteheads, which may or may not be tender to touch
2. May develop into tender cysts
3. Usually appears on face, neck, shoulders and back, often in areas of oily skin
4. May be exacerbated by stress, specific foods, menstruation

Assessment:

1. Impaired skin integrity
2. Risk for infection
3. Disturbed body image
4. Situational low self-esteem

Plan:

1. Wash affected area with warm soap and water at least TID
2. Shower and shampoo at least daily and after exercise.
3. Avoid oily/greasy foods and chocolate.
4. Rule out drug eruptions and secondary bacterial infections.
5. Per medical provider order, Benzoyl Peroxide, topical triple antibiotic and topical Erythromycin

Evaluation:

1. Follow-up as needed.
2. If condition worsens or is not improved within 4 weeks, return to medical clinic for re-evaluation
3. For secondary bacterial infections, cysts or severe acne, which do not respond to above implementations, refer to NP/PA/MD/DO.

Education:

1. Avoid using any greasy creams, oils or cosmetics on affected areas
2. Avoid touching, picking or squeezing lesions
3. Teach patient that psychological stress is often associated with increased outbreaks of acne
4. Educate female patients as to how menstrual cycle hormonal changes may also increase acne exacerbation

ALLERGIES , PEDIATRICS

Definition: ***A localized or systemic hypersensitivity reaction that can occur upon exposure to a particular allergen.***

May be caused by pollen, molds, pet dander, dust mites, detergents, chemicals and certain foods.

Subjective:

1. Complaints of:
   1.1. Runny nose
   1.2. Congestion
   1.3. Sneezing
   1.4. Red and /or watery eyes and/or itchy eyes
   1.5. Itching bumps on skin
   1.6. Scratchy throat
   1.7. Itching of ear canals or feeling of fullness in ears
2. History of recent exposure to known allergen(s)
3. Previous allergy treatment history if known

Objective:

1. Vital Signs, including weight
2. Auscultation of lungs for presence and quality of breath sounds
3. Nose:
   a. Mucous membrane congestion
   b. Edema
   c. Itching
   d. Rhinorrhea with clear secretions
   e. Sneezing
4. Eyes:
   a. Edema
   b. Erythema of sclera
   c. Dark circles under eyes
   d. Occassional clear mucoid discharge
5. Skin:

a. Urticaria
b. Pruritis
c. Blotchy erythema on any portion of skin
d. Fine popular rash without erythema or edema

6. Cough – if productive, describe sputum

Red Flags: If observed, refer to Anaphylaxis guideline, notify physician immediately, and activate 911.

Shortness of Breath (SOB),
Wheezing,
Angioedema,
Hypotension,
Tachycardia,
Decreased Level of Consciousness (LOC).

Assessment:

1. Acute Pain [/Discomfort]
2. Risk for impaired skin integrity
3. Risk for infection
4. Deficient knowledge

Plan:

1. Assess ABC's,
   1.1. If anaphylaxis is suspected,
      1.1.1. Support with BLS and
      1.1.2. Notify NP/PA/MD/DO and EMS immediately.
2. Per Medical Provider's Orders: Give oral antihistamines such as
   2.1. Diphenhydramine (Benadryl)
      2.1.2. Less than 2 years old, not indicated
      2.1.3. 2-6 years, 6.25 mg q 4-6 hours PRN
      2.1.4. 6-12 years, 12.5-25 mg q 4-6 hours PRN
      2.1.5. over 12 years 25-50mg q 4-6 hours PRN

OR

   2.2. Give oral antihistamine/decongestant combination Bompheniramine/psuedoephedrine 1mg/15mg per 5ml, (Dimaphen). **(If patient falls into different dose**

guidelines based on weight and age, follow the weight guidelines)

2.2.1 Less than 6 months, not recommended
2.2.2 6-11 months (14-17 pounds) 2.5 ml q 6-8 hours
2.2.3 12-23 months (18-23 pounds) 3.75 ml q 6-8 hours
2.2.4 2-6 years 5ml q 6 hours
2.2.5 Over 12 years or 100 pounds give adult dose

3. Per Medical Provider's Orders: Treat hives or rash with
   3.1. Per Medical Provider's Orders: Hydrocortisone 1% cream
      3.2.1 Scant amount applied topically to hives or rash q6-12h, prn.
      3.2.2 Use only in limited areas, not for generalized hives over most of the body
4. Increase fluid intake, especially water
5. Document any new allergies in patient's health record per policy.

Evaluation:

1. F/U as needed unless patient continues to experience symptoms or symptoms are not relieved with above medications.
2. Patient or parent reports no increased symptoms such as wheezing, Shortness of Breath (SOB) or increased edema.
3. Congestion reduced with use of p.o. antihistamines or combination antihistamine/decongestants
4. Relief of pruritis hives reported with use of medications

Education:

1. Teach correct administration and dosage of antihistamines decongestants and topical medications as prescribed.
2. Instruct patient or parent as to possible life threatening symptoms, which require immediate notification of clinic
3. Advise patient or parent:
   a. To avoid outside activities when pollen counts are high.
   b. To rinse clothes again in clear water upon return from laundry to remove excess detergent residue.
4. Teach family importance of making medical personnel aware of all known medication allergies at each encounter.

ASTHMA IN PEDIATRICS

Definiti on: Chronic inflammatory disorder of the airway which becomes hyper-responsive causing:

1. Variable, recurrent, reversible airway obstruction
2. Intermittent episodes of wheezing and dyspnea
3. Extrinsic Asthma : The hyper-responsiveness of bronchi to various allergens
4. Intrinsic, Occupational or Exercise-Induced Asthma: The hyper-responsiveness of bronchi to environmental stimuli such as air pollution, industrial fumes, dust or chemicals and exercise

Subjective: 1. Symptoms:

1.1. Wheezing
1.2. Shortness of Breath (SOB)
1.3. Chest tightness
1.4. Cough
1.5. History of asthma and/or allergies
1.6. Recent exposure to noxious stimuli
1.7. Recent or current respiratory infection

Note: Sometimes the only symptom of asthma in a child is a persistent cough.

2. Duration of current symptoms
3. Is relief provided by usual medications?
   3.1. Date of last use of medication?
   3.2. Are steroids used?
   3.3. How frequent is inhaler used?

4. Identify exposures and usual triggers
5. Severity of prior episodes. Was hospitalization required? Was patient ever intubated during an attack?

Objective:

1. Vital signs including pulse oximetry at the beginning and end of therapy
2. Level of consciousness
3. Respiratory rate and depth
4. Expiratory wheezes to auscultation
5. Tachypnea and/or cyanosis
6. Restlessness, anxiety and apprehension
7. Sa02 less than 97% on room air
8. Non-productive cough
9. Decreased peak flow if child is able to perform
10. Use of accessory breathing muscles (common in children)

Red Flags:

Foreign object in airway

Fever with recent history of URI

Acute onset with no previous history of asthma (could indicate anaphylaxis)

History of congestive heart failure

Wheezing and Shortness of Breath (SOB) not relieved after second nebulizer treatment

Assessment:

1. Ineffective breathing pattern, related to bronchospasm;
2. Airway clearance ineffective related to increased respiratory secretions;
3. Anxiety related to difficulty breathing, fear of suffocation, death.
4. Impaired gas exchange related to altered delivery of inspired oxygen/air trapping
5. Activity intolerance

6. Risk for contamination

Plan:

1. Assess vital signs; oxygen saturation and peak flow meter readings (if available/able)
2. If patient has Albuterol (Ventolin) inhaler already prescribed
   a. Administer 2 puffs STAT
   b. May repeat once after 10 minutes if patient remains symptomatic
3. If patient does not have Albuterol already prescribed, per medical provider's orders:
   a. Provide Abluterol premixed nebulizer solution (0.15mg/kg, max 5mg) every 20-30 minutes times three treatments
   b. If there is no response after three treatments, contact provider. Refer patient to ER for further evaluation and treatment.
4. Per medical provider's orders may use humidified oxygen instead of room air to insure O2 Sat above 94%
   a. To administer nebulizer treatment, or
   b. As an adjunct via nasal cannula or pedi-mask during acute attack or if patient appears cyanotic
5. Have parent support child (or patient himself) in an upright position, leaning forward to facilitate breathing
6. Refer to NP/PA/MD/DO for inclusion into Chronic Care Asthma Clinic.
7. **If in any doubt about status of child, call EMS for transport to the ER**

Evaluation:

1. Wheezing absent or reduced
2. Peak flow and Sa02 improved
3. Patient verbalizes less anxiety
4. Patient exhibits respiration and heart rates within normal limits.

Educatio n:

1. Provide information on medications and proper use of inhaler devices, including guidelines to avoid over or under usage;

2. Help patient and parent identify:
   - 2.1. What triggers asthma
   - 2.2. Warning signs of impending attacks
   - 2.3. Strategies for preventing future attacks

3. Instruct patient and parent to:
   - 3.1. Seek treatment for any signs and symptoms of URI's immediately
   - 3.2. Keep well hydrated
   - 3.3. Avoid outdoor activities during extreme cold or when pollution levels are known to be high
   - 3.4. Either avoid situations known to precipitate asthma attacks (exposure to fumes, gases, smoke and particulate matter), or use proper respiratory protection

DIAPER RASH IN PEDIATRIC PATIENTS

Definition: Diaper Rash or diaper dermatitis is one of the most common skin disorders in infants and toddlers.

May occur at any time, to any child, and to the most meticulous parents, but it typically tends to wax and wane, and occurs most frequently between 9 and 12 months of age.

Usually occurs as a primary reaction to irritation by urine, feces, moisture, or friction.

One of the most common types is irritant contact dermatitis. Distribution pattenrs may vary, but it usually involves the convex surfaces where the skin is in greatest contact with the diaper.

Second most common pattern is usually classified as candidial dermatitis. Involves the skin folds and spares the convex surfaces. Rashes in the perineal area may be the result of diarrhea, moisture, and a secondary Candida infection. Rash is bright red, denuded (red, raw, weepy skin) containing macules (flat, discolored lesions) or papules with satellite lesions, which can be inflamed and painful.

Seborrhaic dermatitis is a common condition in infants up to 3 months of age. It affects the face and skin folds, scalp (cradle cap) and the diaper area.

Atopic dermatitis is uncommon in infants under 6 months of age and is usually generalized on the body and face.

Subjective:

1. When did the rash erupt?
2. What treatments were initiated?
3. Did the rash improve with the treatments initiated?

4. Bowel and bladder habits
5. Frequency of diaper changes

Objective:

1. Location of the rash
2. Does it follow a pattern
3. What does it look like? Is it red, pink, wet or dry, and weepy with macules or papules, and satellite lesions?
4. Check infant's mouth for thrush if candidal infection exists

Assessment:

1. Impaired skin integrity
2. Risk for infection
3. Acute Pain

Plan:

1. Prevention is the key to treatment. Education of the parents is key.
2. Cleanse area with water alone or "baby wipes" containing a non-soap cleanser.
3. After soiling, cleanse with soap and water, pat dry, and apply a clean diaper
4. Per Medical Provider's Orders, Diaper creams or ointments, such as Zinc Oxide (Desitin) may be applied as prophylaxis, especially at night or if a diaper rash exists, with every diaper change.
5. Refer to NP/PA/MD/DO if diaper rash is severe or does not resolve.
6. Refer to NP/PA/MD/DO if evidence of thrush.

Evaluation:

1. Upon re-evaluation, rash has disappeared
2. Skin is intact
3. Child does not appear to be in discomfort

Education:

1. Educate parents to keep the infant's skin dry including frequent diaper changes to prevent diaper rash.
2. Educate parents to change soiled diapers as soon as possible to prevent diaper rash.
3. If diaper rash is present, educate parents to change diapers every 2 hours during the day and once at night. If possible, infants should go without a diaper.
4. Educate parents regarding good hand washing before and after changing diapers and feeding infant.
5. Educate parents regarding proper hygiene of nipples and pacifiers.

FEVER/MILD PAIN IN PEDIATRICS

Definition:

Elevation in body temperature above the normal range, usually caused by bacterial and/or viral illness

There are multiple etiologies for fever and mild pain throughout the body.

RED FLAG: Fever in a child less than two months in age requires immediate referral. Provider is contacted and patient admitted to the ER.

Subjective:

1. Onset
2. Duration
3. How high/how much
4. History
   - 4.1. None
   - 4.2. Recent injury
   - 4.3. Infection/virus
   - 4.4. Chronic illness
5. Associated symptoms
   - 5.1. Upper respiratory complaints
   - 5.2. Stiff neck
   - 5.3. Headache
   - 5.4. Earache
   - 5.5. Night sweats
   - 5.6. Cough
   - 5.7. Pain

Objective:

1. Vital signs
   - 1.1. Temperature
   - 1.2. Pulse
   - 1.3. Respiration rate
   - 1.4. Blood pressure
   - 1.5. Weight
2. Exam
   - 2.1. No obvious injuries/deformities/signs of infection noted
   - 2.2. Back pain
   - 2.3. General aches
   - 2.4. Stiff neck/decreased ROM
   - 2.5. Recent weight loss/gain

Assessment:

1. Ineffective thermoregulation
2. Acute pain

Plan:

1. Finding Requiring Referral:
   - 1.1. Temperature greater than101
   - 1.2. Minimal/non-productive cough
   - 1.3. Abdominal/back/neck pain
   - 1.4. Symptomatic weight loss in past week
   - 1.5. Fever greater than 48 hours
   - 1.6. UTI
   - 1.7. Vomiting or diarrhe
   - 1.8. a greater than 24 hours
   - 1.9. + HIV
   - 1.10. + PPD or + CXR
2. Findings not requiring Referral
   - 2.1. Temperature less than 101

2.2. Severe cough
2.3. No generalized aching
2.4. No abdominal/back/neck pain
2.5. Fever less than 48 hours
2.6. Absence of UTI
2.7. Vomiting or diarrhea less than 24 hours

3. Medications
   3.1. Per Medical Provider's Orders, Acetaminophen: dosage by age and/or weight PO or PR every 4-6 hours **(If patient falls into different dose guidelines based on weight and age, follow the weight guidelines)**
      3.1.1. 0-3 months (6-11 pounds) 40mg/dose
      3.1.2. 4-11 months (12-17 pounds) 80mg/dose
      3.1.3. 12-24 months (18-23 pounds) 120mg/dose
      3.1.4. 2-3 years (24-35 pounds) 160mg/dose
      3.1.5. 4-5 years (36-47 pounds) 240mg/dose
      3.1.6. 6-8 years (48-59 pounds) 320mg/dose
      3.1.7. 9-10 years 400mg/dose
      3.1.8. 11-12 yeas 480mg/dose
      3.1.9. Over 12 years or 100 pounds use adult dose
      3.1.10. **Maximum dose:** 4g/24 hours, dose range 10-15mg/kg/dose
   3.2. **Ibuprofen: no longer recommended** . Safety and effectiveness of Ibuprofen in pediatric patients have not been established.
4. General supportive measures can make a child more comfortable
   4.1. Instructions to increase fluids
   4.2. Return to clinic for temperature checks 2 – 3 times a day

Evaluation:

1. On recheck, child is afebrile, pain free
2. No parental or patient complaint of pain or fever

Education :

1. Educate patient and/or parent as to the importance of increased water and other fluids
2. Educate patient and/or parent to notify clinic if the patient's illness worsens (i.e., vomiting, increased fever, change in level of consciousness)
3. Educate parents that cool bath assist to bring down fever
4. Educate parents of signs and symptoms of fever spike
5. Educate parents that over-dressing can be a detriment to plan of care
6. Minimize the amount of clothing covering a patient with fever
7. Educate parents as to cultural differences and medical recommendations to treat fever in children

NAUSEA AND VOMITING IN PEDIATRICS

Definition:

Nausea is a feeling of discomfort in the epigastric area.

Vomiting is the forceful expulsion of stomach contents.
It may result from systemic illnesses, CNS disorders, primary GI disorders, medication side effects and/or allergies.

The most common cause is gastroenteritis. Other serious causes can include: appendicitis, hepatitis, peptic ulcer disease, pancreatitis, biliary tract disease, intestinal obstruction, pyloric stenosis, lactose intolerance, intussusception, urinary tract infections, and diabetes. Allergic reaction to formula is also common during the first two months of life.

RED FLAGS: Bowel obstruction and pregnancy should be ruled out.

Abdominal pain localized in RLQ
Distended, firm abdomen
Vomiting one to four hours after eating may indicate gastric or duodenal disease.
Neurological changes and/or tachycardia may indicate electrolyte imbalance.
Fever greater than 101
Awakens child from sleep
Pregnancy in adolescent female
Dehydration and electrolyte imbalance secondary to prolonged vomiting especially in small children
Threat of aspirati on present with prolonged vomiting
Testicular or ovarian torsion
Odor from oral cavity indicating poison ingestion

Subjective:

1. Onset, duration, number of episodes over time
2. History of episodes and associated symptoms
3. Nutritional assessment, weight gain or loss
4. Medications and/or substance use
5. Females – LMP, Pregnancy

Objective:

1. Vital signs, weight, temp. and head circumference
3. Hydration Status
4. Mouth and Pharynx:
   - 4.1. Inspect lips for color, symmetry, and presence of abnormalities
   - 4.2. Feel anterior fontanel, should be level and soft, call provider if sunken or bulging.
   - 4.3. Assess tongue, noting color, coating, ulcers, and moisture.
   - 4.4. Note any significant mouth odors
   - 4.5. Assess pharynx for signs of inflammation and the presence of tonsils, exudate, swelling or ulceration.
   - 4.6. Check Abdomen for Costo Vertebral Angle (CVA) tenderness
5. Abdomen
   - 5.1. Visualize
   - 5.2. Auscultate for bowel sounds
   - 5.3. Observe for obvious masses, organomegaly
   - 5.4. Palpate gently for rebound, guarding and tenderness

Assessment:

1. Risk of fluid volume deficit
2. Altered nutrition, less than body requirements

Plan:

1. Refer to provider if patient meets ANY of the

criteria for any of the Red Flag circumstances mentioned above.

2. Per Medical Provider's Orders, Withhold liquids and foods until vomiting is stopped, then begin stepwise increase in foods as tolerated:
   a. small frequent amounts of clear liquids or crushed ice.
   b. start with juice, 7-up, ginger ale, dry crackers, toast, etc. No breast or bottle milk for 24 hours
   c. encourage soft, bland foods
3. Avoid highly spiced, fried, or greasy foods or acid drinks like sodas.
4. Encourage eating slowly

Evaluation:

1. Return to clinic for daily weight, vital signs monitoring

Education :

1. Avoid foods that may lead to nausea and vomiting
2. Advise patient/parent to return to clinic if patient experiences continued or increased abdominal pain, blood in vomitus or stools.

UPPER RESPIRATORY TRACT INFECTION IN PEDIATR ICS

Definition:

An acute, mild and self-limiting syndrome caused by a viral infection of the upper respiratory tract mucosa

Subjective:

(as stated by parent or child):

1. Chief complaint: duration of symptoms
2. Respiratory symptoms including: runny nose, sore throat, cough, wheezing, dyspnea, stridor and blood tinged sputum
3. Inability or lack of desire to swallow
4. Fever, chills, anorexia, nausea, vomiting, diarrhea, failure to take bottle or breastfeed
5. History of allergies or asthma

Red Flag: Bloody sputum, stridor, wheezing, pallor or cyanosis, retractions (Contact provider if any of the above is pr esent)

Objective:

1. Vital signs
2. Auscultate heart and lungs, respiration rate and observe for retractions
3. Examine conjunctiva, ears, nose, and throat
4. Palpate lymph nodes, check capillary refill time
5. Including O2 saturation, on admit and discharge from encounter

Assessment:

1. Ineffective airway clearance.
2. Ineffective breathing pattern

Plan:

1. Increase fluid intake (juice, water, clear carbonated beverages) as tolerated
2. No dairy products while ill
3. Salt water gargles for sore throat if old enough to understand process –1 tsp of salt in 8 oz warm water, more for adolescents
4. Saline nose drops for infants only less than one year of age for severe nasal congestion followed by bulb aspiration of nares prior to feeding or sleep
5. If no relief from above after 48 hours, may use the following meds as needed, per the medical provider's orders:

a. Cough:

i. Guaifenasin: 100mg/5ml with dextromethorphan 10mg/5 ml

(If patient falls into two different dosages depending on age and weight, use the dosage based on the patient's weight)

1. Not recommended under 6 months or 14 pounds
2. 6-11 months (14-17 pounds): 1.25ml q 8 hours
3. 12-23 months (18-23 pounds): 2.5 ml q 8 hours
4. 2-6 years (24-47 pounds): 2.5 ml q 6 hours
5. 6-12 years (48 to 95 pounds) 5 ml q 6 hours

OR

ii. Guaifenasin 100mg/5 ml

(If patient falls into two different dosages depending on age and weight, use the dosage based on the patient's weight)

1. Not recommended under 6 months or 14 pounds
2. 6-11 months (14-17 pounds): 1.25ml q 6 hours
3. 12-23 months (18-23 pounds): 2.5 ml q 6 hours
4. 2-6 years (24-47 pounds) 2.5-5ml q 6 hours
5. 6-12 years (48-95 pounds): 5-10 ml q 6 hours
6. Over 12 years or 100 pounds give adult dose

b. Congestion, Sneezing:

i. Dimaphen (bropheniramine 1mg/5ml and pseudoephedrine 15mg/5 ml)
(If patient falls into two different dosages depending on age and weight, use the dosage based on the patient's weight)

1. less than 6 months not recommended
2. 6-11 months (14-17 pounds) 2.5ml q 6-8 hours
3. 12-23 months (18-23 pounds) 3.75 ml q 6-8 hours
4. 2-6 years 5ml q 6 hours
5. 6-12 years 10ml q 6 hours
6. Over 12 years or 100 pounds give adult dose
7. **Maximum:** 4 doses daily

c. Fever, mild pain

i. Acetaminophen:
(If patient falls into two different dosages depending on age and weight, use the dosage based on the patient's weight)

1. 0-3 months (6-11 pounds) 40mg/dose
2. 4-11 months 912-17 lbs) 80mg/dose
3. 12-24 months (18-23 lbs) 120mg/dose
4. 2-3 years (24-35 lbs) 160mg/dose
5. 4-5 years (36-47 lbs) 240mg/dose
6. 6-8 years (48-59 lbs) 320mg/dose
7. 9-10 years 400mg/dose
8. 11-12 years 480mg/dose
9. Over 12 years or 100 pounds give adult dose
10. **Maximum dose:** 4g/24 hours, dose range 10-15mg/kg/dose

ii. Ibuprofen **no longer recommended** . Safety and effectiveness of Ibuprofen in pediatric patients have not been established.

Evaluation:

Return to clinic in 3 days if symptoms persist or sooner if increased fever or difficulty breathing.

Education :

1. Review the etiology, course, and proper treatment of the common cold.
2. Instruct on increased fluids (provide an amount).
3. Proper use of medications.
4. If they smoke give information on smoking cessation.
5. Instruct on proper hand washing.
6. Provide education on hand washing and common colds in the appropriate language if available.

DENTAL

RN

GUIDELINES

DENTAL – LACERATION OF ORAL STRUCTURES

Definition: Laceration of oral tissues or those associated with them, which may include tongue and lips, and may have been caused by iatrogenic trauma, broken appliance or other.

Subjective: Document factors influencing patient's condition:

1. Patient may have orthodontic braces.
2. Patient may use a removable prosthetic appliance.
3. History of trauma.
4. Pain upon chewing.
5. Report of bleeding from mouth.

Objective: Document:

1. Visible broken intra-oral appliance.
2. Visible broken orthodontic wire.
3. Evidence of extra-oral soft tissue contusion.
4. Bleeding - location, amount; may originate from tissues in close proximity to broken appliance.

Assessment:

1. Altered integrity of oral mucous membranes.
2. Impaired skin integrity.
3. Acute pain

Plan:

1. Refer to NP/PA, physician, or dentist if necessary.
2. Rinse mouth with 50% peroxide/50% water solution tid/prn

for minor intraoral lacerations.

Evaluation: Follow-up within 24 hours to assess bleeding and inflammation.

Education:

1. Advise patient not to wear broken appliances.
2. Teach patient to keep wound clean until healing is complete.

DENTAL – TOOTH ERUPTION PAIN

Definition: Pain caused by the eruption process of a permanent tooth. Usually associated with molar eruption, specifically with third molar or wisdom tooth eruption.

Subjective: Document factors influencing patient's condition:

1. Patient unable to fully open mouth, with or without discomfort.
2. Complaints of a low-grade fever associated with eruption process.
3. Intermittent pain.

Objective: Document:

1. Patient between the ages of 17-25 years old.
2. Any presence of a partially erupted tooth.
3. Inflammation of the tissues surrounding the partially erupted tooth.
4. Pain elicited by full mouth opening, or by manual palpation.

Assessment:

1. Impaired tissue integrity
2. Acute pain secondary to tooth eruption.

Plan:

1. Rinse mouth tid / prn with 50% Hydrogen Peroxide and 50% water solution.
2. Give Tylenol or Motrin according to RN Guideline for Pain.
3. Refer to NP/PA, physician, or dentist.

Evaluation:

1. Advise patient that if condition worsens, return to sick call.
2. Follow-up as instructed by dentist.

Education:

1. Advise patient that it is the normal eruption process.
2. Avoid eating on the affected side.
3. Eat softer foods if pain is associated with eating hard foods on the affected side.
4. Take medicine as prescribed.

DENTAL – APHTHOUS ULCERS

Definition: Ulceration of the unattached mucosa intraorally. Ulcer is typically a round ulcer with a grayish membrane surrounded by an erythematous border. If ulcers are numerous and in close proximity they may coalesce.

Subjective: Factors influencing patient's condition:

1. For how long has the ulcer(s) been present?
2. How often do the ulcers recur?
3. Is patient under extreme stress?
4. Are ulcers painful when touched or when in contact with salt or spicy foods?

Objective:

1. Size of ulcer and quantity. Aphtous Minor vs. Aphtous Major.
2. Ulcers are only located in "movable" tissue, i.e.; oral mucosa, tongue.
3. Ulcers are round and have a grayish-white membrane with erythematous border.
4. Ulcers are painful to touch.
5. Patient may have low-grade fever.

Assessment:

1. Altered integrity of oral mucous membranes.
2. Acute pain related to disruption of mucous membrane integrity.

Plan:

1. May use warm salt-water rinses tid / prn for comfort.
2. Assure patient that healing takes place within 10-14 days.
3. Avoid spicy foods.

Evaluation:

Return to the clinic if condition worsens or lesions do not heal in 14 days.

Education:

1. Reassure patient that lesions are benign and that they may recur often.
2. May be associated with stress.

DENTAL – FACIAL SWELLING

Definition: Intraoral or extraoral swelling on either jaw or structure associated with them. May be associated with a carious, fractured, or impacted tooth.

Subjective: Document factors influencing patient's condition:

1. Pain associated with the involved tooth.
2. Pain associated with opening and closing of the mouth.

Objective: Document:

1. Swelling adjacent to affected site intra- or extra-orally.
2. Patient may exhibit all or some of the following symptoms of infection: lymphadenopathy, fever, trismus, or suppuration.
3. Visible fractured tooth or fragment imbedded in the gum.
4. A fistula may be present with a draining sinus.
5. Patient may not be able to open mouth fully.

Assessment:

1. Impaired skin integrity.
2. Acute pain due to facial swelling.
3. Altered body image due to facial swelling.

Plan:

1. Refer to NP/PA, physician, or dentist.

Evaluation:

1. Follow-up daily for the next three days or until marked improvement.
2. Return to dentist for proper treatment following prescribed therapy.

Education:

1. Counsel patient on proper oral hygiene measures as ordered by dentist.
2. Counsel patient on importance of completing prescribed therapy in order to avoid re-infection.

DENTAL – FOREIGN OBJECT WEDGED IN DENTITION

Definition: Foreign object wedged between teeth or in the periodontal sulcus.

Subjective: Document factors influencing patient's condition:

1. Oral habits to include toothpick grinding or sucking on foreign objects.
2. Pressure felt between two teeth or in the periodontal sulcus.
3. Pain may be present depending on size and location of object.
4. Report of bleeding.

Objective: Document:

1. Any visible foreign object wedged between teeth or in the sulcus.
2. If the object is located via manual palpation, document location.
3. Bleeding may be present if wedged in the periodontal sulcus or interdentally.

Assessment:

1. Dentition, impaired
2. Acute pain secondary to intraoral injury.

Plan:

1. If object is wedged between teeth, attempt to remove using dental floss.

2. If unable to remove object, refer to NP/PA, physician, or dentist.

Evaluation:

1. Follow-up via sick call if pain persists or signs/ symptoms of infection develop after object is removed.

Education:

1. Educate patient as to risks of putting foreign objects in the mouth.

DENTAL – FRACTURED TOOTH

Definition: Partial or complete fracture of tooth involving enamel, enamel and dentin, or enamel, dentin and pulp chamber.

Subjective: Document factors influencing patient's condition:

1. History of recurrent decay of involved tooth.
2. History of bruxism (clenching of teeth associated with grinding).
3. Patient has an underlying oral habit which involves biting on hard substances, i.e.; ice, metal objects, hard candy.
4. Pain is elicited when biting down on the tooth in question.

Objective: Document:

1. Obvious fracture of the crown of the tooth involved.
2. When pressure is applied to the tooth, pain is present.
3. Can move a part of the tooth independently of the rest of the tooth.
4. Tooth involved may be weakened by recurrent decay.
5. If filling was present, it may have occupied more than 40% of crown.

Assessment:

1. Dentition, impaired due to fractured tooth.
2. Acute pain due to fractured tooth.

Plan:

1. Refer to NP/PA, physician, or dentist.

Evaluation:

1. If patient shows signs of bruxism, refer to mental health for evaluation.

Education:

1. Counsel patient to avoid biting on hard substances.
2. Educate patient on the need to visit dentist at least once a year to treat caries which could lead to tooth fracture.

DENTAL – FRACTURED JAW

Definition: Complete or partial disruption of the mandibular or maxillary bone structure.

Subjective: Document factors influencing patient's condition:

1. Recent trauma to the face.
2. History of lytic bone disease.
3. Pain in the affected bone which is aggravated by exercise and relieved by rest.
4. Inability to fully bring teeth together.

Objective: Document:

1. Fissure present intra-orally in the alveolar mucosa.
2. Misaligned dentition when asked to fully close or bring teeth together.
3. Misalignment of the incisor teeth.
4. Complete or partial osseous separation of either jaw bone.
5. Pain elicited by manual palpation.

Assessment:

1. Acute pain secondary to jaw injury.
2. Risk for injury
3. Impaired oral mucous membrane
4. Self-care deficit: feeding
5. Swallowing, impaired

6. nutrition: less than body requirements, imbalanced

Plan:

1. Refer to NP/PA or physician.
2. Prepare to send patient to the Emergency Room.
3. Have intra-oral wire cutters available in case of an emergency following surgical repair.

Evaluation:

1. Follow-up as indicated by the provider or oral surgeon.
2. If symptoms of malaise appear, have patient report to sick call.

Education:

1. Explain prescribed medications and dietary supplements.
2. Advise patient not to exercise unless cleared by provider.
3. Maintain adequate hydration by ingesting 3000 ml of fluid daily.

DENTAL - GINGIVITIS

Definition: Inflammation of the gingival tissues which may occur in an acute, subacute or chronic form and with or without gross gingival enlargement or recession.

Subjective: Document any factors influencing patient's condition:

1. History of swelling, discomfort, or bleeding from gums.
2. Complaint of faulty or irritating restorations or appliances.
3. History of nutritional disturbances.
4. History of drug reaction or allergies.
5. History of pregnancy, diabetes and other endocrine dysfunctions.

Objective: Document:

1. Reddening of the crest of the alveolar gingiva.
2. Tooth malposition with retained food particles.
3. Food impaction.
4. Presence of dental plaque or calculus.
5. Bleeding upon periodontal probing.
6. Halitosis (bad breath).
7. Mouth- breathing.

Assessment:

1. Impaired oral mucous membrane.
2. Acute pain.

Plan: Give oral mouthwash, oral peroxide rinses (1/2 water and ½ hydrogen peroxide mixture) or warm saline rinses bid.

Evaluation: If condition worsens, or is not improving return within four weeks.

Education:

1. Review oral hygiene procedures.
2. Demonstrate proper brushing techniques.
3. Educate patient on the need for proper oral hygiene.
4. Provide handout on management of gingivitis.

DENTAL – TOOTHACHE

Definition: The presence of pain in a tooth or teeth which could be caused by the presence of decay, trauma, infection, demineralization, or a combination thereof.

Subjective: Document factors influencing patient's condition:

1. Pain elicited when eating sweet substances.
2. Pain elicited when drinking cold/hot drinks.
3. Pain elicited when chewing on hard foods.
4. Pain which is intermittent in nature and is not related to a specific stimuli.
5. History of old restorations which are deteriorating.
6. Dietary habits.
7. Presence or absence of localized pain elicited by any stimuli.

Objective: Document:

1. Any visible perforation in any surface of the affected tooth.
2. An old restoration with broken margins.
3. Patient demonstrates sensitivity to percussion of the affected tooth.
4. Patient demonstrates sensitivity to thermal changes (air, ice, or warm wax applied directly to the surface of the tooth).

5. Swelling or discoloration of surrounding tissue.

Assessment:

1. Impaired oral mucous membrane.
2. Pain (acute) due to dental decay, trauma, infection, or other.

Plan:

1. Treat pain with Tylenol or Motrin per RN Guideline for pain and refer to NP/PA, physician, or dentist.

Evaluation:

1. Advise patient to return to sick call if condition worsens after follow-up dental therapy.

Education:

1. Avoid chewing on affected tooth or teeth until seen by dentist.
2. Discuss dietary habits and make appropriate suggestions, i.e. limit the sugar intake.
3. Educate patient on proper oral hygiene.

DENTAL – TOOTH AVULSION

Definition: A partial or complete displacement of a permanent or deciduous tooth from its socket due to trauma.

Subjective: Document factors influencing patient's condition:

1. History of recent trauma to the affected jaw.
2. Patient may describe loss of tooth with or without pain.
3. When did the tooth come out?

Objective: Document:

1. Obvious empty socket.
2. Patient may have tooth in hand.
3. Bleeding from socket if recent trauma; blood on towel or napkin.
4. Blood clot in socket if not recent trauma.
5. Inability to occlude properly due to partial tooth avulsion.
6. Possible fracture of the cortical bone surrounding socket.

Assessment:

1. Impaired oral mucous membrane.
2. Nutrition: less than body requirements, risk for
3. Pain (acute) due to dental trauma.

Plan:

1. If recent avulsion (within 20 minutes), may re-implant tooth back into socket and ask patient to apply gentle pressure with gauze. Refer to NP/PA, physician, or dentist.
2. If avulsion is not recent, place tooth in container with saliva from patient and refer immediately to NP/PA, physician, or dentist.
3. In either case (#1, or 2), do not attempt to clean tooth or disturb periodontal ligament fibers on root surface.
4. Give medications as ordered.

Evaluation:

1. Follow-up within twenty- four hours or as directed.
2. Follow-up with dentist as indicated.

Education:

1. Do not chew on re-implanted tooth.
2. Take medications as prescribed.